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The Invisible Patient (reviewing SALLY SATEL, HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE (2000))

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THE INVISIBLE PATIENT

BOOK REVIEW: *Sally Satel, How Political Correctness Is Corrupting Medicine* (New York: Basic Books 2000)

Barbara A. Noah*

[F]or all of the transformations wrought by the masterful new engines of medicine and by their multitudinous varieties of fuel, there is one singular ingredient of the art of healing that should not be allowed to vanish. That ingredient, so basic and so changeless, is a relationship; it takes place in the quiet surroundings of the sick-room or in the doctor's office. There occurs in those protected places a transaction which, in a most fundamental way, is an act of giving, and it has to do with such elemental things that pass between two people as listening, and touching, and talking [I]t is something that I have never been able to approach with anything but awe, because the experience of healing is a joining between doctor and patient in which one human being is privileged to help another.¹

I. INTRODUCTION

Although Sherwin Nuland's idealized vision of the doctor-patient encounter no doubt exists for some, it must ring hollow for many African-American patients. Despite the fact that African-Americans suffer from a variety of health problems at disproportionately higher rates than whites,² inequities in the medical system, particularly the lack of health insurance, make access to care more difficult for minorities. Yet the problem of racial disparities in health care is more complex than simply inadequate access to care: communication difficulties between physician and patient and dispa-

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The title of this essay is, of course, inspired by Ralph Ellison's ground-breaking novel. See RALPH ELLISON, *THE INVISIBLE MAN* (1952).

1. SHERWIN B. NULAND, *DOCTORS* 488 (1988).

2. See Council on Ethical & Judicial Affairs, *Black-White Disparities in Health Care*, 263 JAMA 2344, 2344-45 (1990) (noting that the infant mortality rate among African-Americans is double that of whites and that the African-American life expectancy is six years shorter than the life expectancy of whites); Kaiser Family Found., Comm'n on Medicaid & the Uninsured, *Key Facts* (2000), available at <http://www.kff.org> (visited July 1, 2001) (noting that almost one quarter of African-Americans have neither private health insurance nor Medicaid coverage, compared with only fifteen percent of whites and that the uninsured are three times as likely to be hospitalized from complications of diabetes).

rate provisions of covered services also contribute substantially to health disparities between the races. Numerous studies concerning every type of care, from the use of coronary drugs and complex coronary procedures,³ to organ transplantation,⁴ and the provision and availability of pain medications,⁵ strongly suggest that African-American patients do not receive the same care as white patients when they seek medical treatment.⁶ These differential utilization patterns persist even when investigators control for confounding variables such as income, level of education, insurance coverage, co-morbid factors, and stage of disease.

The role of race in health care has generated substantial controversy within the medical profession. For example, in a recent book, *PC, M.D.: How Political Correctness Is Corrupting Medicine*,⁷ Dr. Sally Satel charges that “politically correct medicine, . . . powered by the idea that injustice produces disease . . . interfere[s] with effective treatment” and “puts ideology before patients.”⁸ The book has drawn both criticism and praise from a variety of sources,⁹ and the *New York Times* featured a biographical sketch

3. See, e.g., Jeroan J. Allison et al., *Racial Differences in the Medical Treatment of Elderly Medicare Patients with Acute Myocardial Infarction*, 11 J. GEN. INTERNAL MED. 736 (1996); John G. Canto et al., *Relation of Race and Sex to the Use of Reperfusion Therapy in Medicare Beneficiaries with Acute Myocardial Infarction*, 342 NEW ENG. J. MED. 1094, 1096–97 (2000) (concluding that African-Americans were less likely than whites to receive “potentially life-saving” reperfusion therapy); Herman A. Taylor et al., *Management and Outcomes for Black Patients with Acute Myocardial Infarction in the Reperfusion Era*, 82 AM. J. CARDIOLOGY 1019, 1020–21 (1998) (concluding that African-Americans are less likely than whites to receive intravenous thrombolytic therapy to improve blood flow through occluded arteries, coronary arteriography, and other elective catheter-based procedures).

4. See, e.g., John Z. Ayanian et al., *The Effect of Patients' Preferences on Racial Differences in Access to Renal Transplantation*, 341 NEW ENG. J. MED. 1661 (1999); Arnold M. Epstein et al., *Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Underuse or Overuse?*, 343 NEW ENG. J. MED. 1537 (2000).

5. See, e.g., Vence L. Bonham, *Race, Ethnicity, and Pain Treatment: Striving to Understand the Causes and Solutions to the Disparities in Pain Treatment*, 29 J. L. MED. & ETHICS 52 (2001); R. Sean Morrison et al., *“We Don’t Carry That”—Failure of Pharmacies in Predominantly Nonwhite Neighborhoods to Stock Opioid Analgesics*, 342 NEW ENG. J. MED. 1023 (2000); Knox H. Todd et al., *Ethnicity and Analgesic Practice*, 35 ANNALS EMERGENCY MED. 11, 13 (2000) (finding that, in the studied group of patients presenting in an emergency department with long-bone fractures, only fifty-seven percent of African-Americans received analgesics compared with seventy-four percent of white patients); Knox H. Todd et al., *Ethnicity as a Risk Factor for Inadequate Emergency Department Analgesia*, 269 JAMA 1537 (1993).

6. See Morehouse Sch. of Med., Morehouse Med. Treatment & Effectiveness Ctr., *A Synthesis of the Literature: Racial and Ethnic Differences in Access to Medical Care* (1999), available at <http://www.kff.org/content/1999.pdf> (visited July 1, 2001) (summarizing health literature from 1985–1999, including 180 studies—some controlling for explanatory variables and some not—that provide evidence of racial disparities in health services).

7. SALLY SATEL, *PC, M.D.: HOW POLITICAL CORRECTNESS IS CORRUPTING MEDICINE* (2000).

8. *Id.* at 6.

9. See, e.g., Eric Chevlen, *The Indoctrinologists: Sally Satel Diagnoses Politically Correct Medicine*, WKLY. STANDARD, Jan. 22, 2001, at 33 (providing a favorable review); Daniel M. Fox, *PC, M.D.: How Political Correctness Is Corrupting Medicine*, 344 NEW ENG. J. MED. 462, 462 (2001) (book review) (opining that Dr. Satel “dispenses harsh and inadequately documented opinions about issues and individual persons,” “exaggerates the influence of” politically correct advocates, “oversimplifies complicated matters,” and “invents data”); Scott Gottlieb, *Germs Are Bad Enough: Is Social Injustice Enough to Make You Sick?*, WALL ST. J., Jan. 17, 2001, at A24 (praising the book, and noting that “the best medical evidence may collide with social goals and ideological expectations”).

about the author.¹⁰ In a series of chapters addressing different health care issues and contexts, including mental health,¹¹ the nursing profession,¹² gender bias in health care,¹³ and drug addiction during pregnancy,¹⁴ Dr. Satel condemns, sometimes persuasively, those who publicly criticize inequities in the health care system as “indoctrinologists.”¹⁵ But her discussion of racial disparities in medical care,¹⁶ which has drawn the most attention, suffers from serious flaws. As it happens, Dr. Sherwin Nuland offered one of the most supportive reviews of Satel’s book, but even he roundly criticized Dr. Satel’s position on the role of race in medicine.¹⁷

This review will focus on the issue of racial disparities in the provision of health care. Although Dr. Satel correctly criticizes the occasional sloppy use of empirical data to support conclusions about racism in health care delivery, her cavalier dismissal of an overwhelming body of evidence documenting differential medical treatment of minority patients demands a response. This review will canvas some of that evidence and will offer some suggestions that may improve the quality of communication between physicians and patients and ultimately foster equity in the provision of health services to all Americans. The evident disparities in medical care have provoked some observers to condemn the health care system and its providers as “racist.” Most commentators, however, recognize that race, entangled with other factors, plays a more complex role in creating health disparities. During the past decade, discussions about disparities in treatment have gathered momentum in the medical community. Physicians and public health experts have initiated a thoughtful and increasingly candid public dialogue about the troubling evidence of inferior medical care for minority patients. While laudable, the research in the medical community only diagnoses the problem; as some commentators have recently observed, correcting the pattern of disparities in medical treatment will obviously prove more difficult.¹⁸

The sheer volume of evidence suggests that at least some of the differential medical care experienced by African-American patients and other

10. See Erica Goode, *A Critic Takes on Psychiatric Dogma, Loudly*, N.Y. TIMES, Mar. 6, 2001, at D5 (describing Dr. Satel’s views as “provocative” and reviewing her career).

11. See SATEL, *supra* note 7, at 45–76, 193–230; see also Lars Noah, *Pigeonholing Illness: Medical Diagnosis as a Legal Construct*, 50 HASTINGS L.J. 241, 272–74, 280–81, 293–94 (1999) (criticizing the proliferation of mental illnesses officially recognized by the American Psychiatric Association).

12. See SATEL, *supra* note 7, at 77–101.

13. See *id.* at 103–30.

14. See *id.* at 131–54.

15. See *id.* at 6, 231.

16. See *id.* at 155–92.

17. See Sherwin B. Nuland, *Indoctrinology*, NEW REPUBLIC, Feb. 19, 2001, at 34, 37 (providing a generally supportive review, but noting that Satel’s chapter on “Race and Medicine” is “less persuasive” than her other chapters, and that “[h]er statistics, and her descriptions of biological differences in disease patterns, read like feeble protests in the face of the experience of anyone who has ever trained in the teaching divisions of a large hospital”).

18. See, e.g., M. Gregg Bloche, *Race and Discretion in American Medicine*, 1 YALE J. HEALTH POL’Y L. & ETHICS 95 (2001) (providing a detailed description of the problem of disparate provision of health care and examining various institutional and legal responses).

racial and ethnic minorities arises from biases or racial stereotypes on the part of medical providers. When a physician fails to disclose all appropriate treatment options to a patient based on some racial stereotype or bias, and that patient then receives suboptimal care, the patient has only limited options for redress. Although the standard of care in medical malpractice assumes that a physician will exercise his or her best professional judgment when selecting among available diagnostic tests or treatments, the inherent uncertainty in medical practice usually leaves some leeway for the physician to articulate a neutral, medical reason for preferring one option over the others. For this reason, patients will find it difficult to prove that the physician discriminated, either consciously or unconsciously, on the basis of the patient's race or ethnicity.¹⁹ After examining the complex problem of disparate provision of medical care, this review will suggest an approach that emphasizes improved communication between physician and patient, calls for an increased commitment to diversity in medical education, and considers tort remedies to redress cases of individual discrimination in health care.

II. MEDICAL APARTHEID: MOUNTING EVIDENCE OF INFERIOR HEALTH CARE FOR MINORITY PATIENTS

A. *Medical Research Findings on the Relationship Between Race and Care*

The accumulating evidence demonstrating disparate provision of medical care to minority patients is difficult to ignore. Of course, inexplicable geographic and other variations have long existed in practice patterns,²⁰ but studies that attempt to isolate the role of race suggest something other than random variability. Recent empirical studies, some of which are briefly described below, evaluate numerous examples of race-based differential utilization patterns of therapeutic procedures, diagnostic tests, and other forms of care.²¹ Because the choice among treatment modalities

19. Cf. Marianne L. Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239, 257-60 (1994) (arguing that advocates in civil rights cases must attempt to relate experiences of racism "in a way that will be more meaningful in the realm of law").

20. See Mark R. Chassin et al., *Variations in the Use of Medical and Surgical Services by the Medicare Population*, 314 NEW ENG. J. MED. 285, 287-89 (1986); Paul D. Cleary et al., *Variations in Length of Stay and Outcomes for Six Medical and Surgical Conditions in Massachusetts and California*, 266 JAMA 73, 79 (1991).

21. Much of the following discussion focuses on health disparities between African-Americans and white patients, and on the relationship between white physicians and African-American patients, in part because most of the studies evaluating patterns of care focus on the contrasts between these two racial groups. See Council on Ethical & Judicial Affairs, *supra* note 2, at 2344. Some scholars have criticized the application of conclusions about relations between whites and African-Americans to white relations with other minority groups. See, e.g., Juan F. Perea, *The Black/White Binary Paradigm of Race: The "Normal Science" of American Racial Thought*, 85 CAL. L. REV. 1213 (1997). Because the discussion that follows emphasizes the importance of physicians getting to know their patients as individuals and the importance of individualized medical decision making, many of the suggestions apply equally well to relations between physicians and patients of any race or ethnicity.

should depend on the physiological condition of the individual patient, researchers examining patterns of care should be able to point to a medical explanation for data demonstrating a clustering of African-American patients around one treatment modality. The data suggest, however, that disease stage, co-morbid conditions, insurance coverage, income, and even educational differences and patient preferences fail to explain fully the patterns of apparent underprovision of care for minority patients. Even when financial and nonfinancial barriers to care are removed, racial and ethnic minorities continue to receive care that is different from, and often inferior to, that received by white patients.²²

The differing patterns of medical service provision for African-Americans fall into two categories. First, physicians appear to underutilize certain preventive and diagnostic medical procedures with these patients.²³ Second, certain medical procedures, typically treatments of last resort, appear to be used more frequently for African-Americans. These two categories of differential utilization reflect two separate but related problems with health care delivery for minority patients: lack of adequate access to state-of-the-art care in some circumstances and suboptimal management of chronic disease because of inadequate access to primary and preventive care in others. The studies described below provide a range of examples that illustrate the different ways in which race apparently factors into the utilization of treatments or diagnostic tests for different populations of patients.

An independent study published by a team of investigators affiliated with the Health Care Financing Administration (HCFA) presents evidence of both types of differential utilization patterns.²⁴ The HCFA investigators

22. Dr. Satel observes that a patient sometimes does not receive a potentially efficacious medical procedure simply because the institution caring for that patient lacks the equipment or personnel to provide the particular service. See SATEL, *supra* note 7, at 165. She also describes studies that suggest that racial variations in care "melt away" in certain settings, such as Veterans' Affairs facilities, that provide care for special populations. See *id.* at 165-66. Although both assertions are correct, these phenomena account for only a small portion of the racial disparities in health care delivery that have been documented. Neither explanation adequately addresses the large body of research that demonstrates, in carefully designed studies that control for multiple variables, continued variations in the rates of certain medical procedures according to race.

23. One source defines "underuse" as "failure to provide a health care service when it would have produced a favorable outcome for a patient." Mark R. Chassin, Robert W. Galvin & The Nat'l Roundtable on Health Care Quality, *The Urgent Need to Improve Health Care Quality*, 280 JAMA 1000, 1002 (1998). Efforts to reach a consensus about what constitutes appropriate care for particular conditions have not, however, always succeeded. See John Z. Ayanian et al., *Rating the Appropriateness of Coronary Angiography—Do Practicing Physicians Agree with an Expert Panel and with Each Other?*, 338 NEW ENG. J. MED. 1896 (1998); Rolla Edward Park et al., *Physician Ratings of Appropriate Indications for Six Medical and Surgical Procedures*, 76 AM. J. PUB. HEALTH 766 (1986); Charles E. Phelps, *The Methodologic Foundations of Studies of the Appropriateness of Medical Care*, 329 NEW ENG. J. MED. 1241 (1993); Paul G. Shekelle et al., *The Reproducibility of a Method to Identify the Overuse and Underuse of Medical Procedures*, 338 NEW ENG. J. MED. 1888 (1998). Reasonable minds may differ about how best to treat a particular patient, but adequate consensus exists with respect to certain conditions to justify a conclusion that physicians sometimes underuse beneficial care for some of their patients.

24. See Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791 (1996). An editorial accompanying the study

combined Medicare administrative data from 1993 covering more than twenty-six million beneficiaries with Census data on estimated household income, to determine whether and to what extent race and income affect the utilization of health care services. The study was one of the first large population studies that attempted to control for income among different populations, allowing the investigators to isolate more accurately variations in the utilization of health care services based on race alone.²⁵ Even after adjusting for income differentials, the data suggested a tendency on the part of health care providers to pursue less aggressive therapies and diagnostic procedures for African-American patients. For example, the study concluded African-American women were twenty-five percent less likely than white women to have mammograms.²⁶ The HCFA study data also demonstrated that white patients were at least twice as likely as African-American patients to undergo coronary angioplasty and coronary-artery bypass surgery.²⁷ Numerous other studies looking at rates of various cardiac and vascular procedures by race have found similar patterns.²⁸

In contrast, other procedures were performed more frequently among African-American patients. After adjusting for income, the HCFA study concluded that African-Americans underwent amputation of a lower limb, typically done as a result of circulatory complications associated with poorly

suggests a pair of methodological weaknesses: the investigators relied solely on Medicare administrative data because they lacked access to medical records, and they used aggregated rather than individual income data. See H. Jack Geiger, Editorial, *Race and Health Care—An American Dilemma?*, 335 NEW ENG. J. MED. 815, 815–16 (1996). Another, more recent, study of utilization of Medicare services confirms the findings of the HCFA study. See Steven M. Asch et al., *Measuring Underuse of Necessary Care Among Elderly Medicare Beneficiaries Using Inpatient and Outpatient Claims*, 284 JAMA 2325, 2330–31 & tbl.2 (2000) (concluding that for sixteen out of forty necessary care indicators, African-Americans received care significantly less often than whites).

25. See Gornick et al., *supra* note 24, at 792. Previous studies examining the utilization of health services among different racial groups often used race as a surrogate for socioeconomic status; thus, these studies frequently attributed differences in the quality and quantity of care afforded to minority patients to disparities in patient income. See, e.g., Kenneth C. Goldberg et al., *Racial and Community Factors Influencing Coronary Artery Bypass Graft Surgery Rates for All 1986 Medicare Patients*, 267 JAMA 1473 (1992) (finding disparities in income to be an important factor in the differences in rates of coronary artery bypass grafting between African-American and white Medicare patients); Robert A. Hahn & Donna F. Stroup, *Race and Ethnicity in Public Health Surveillance: Criteria for the Scientific Use of Social Categories*, 109 PUB. HEALTH REP. 7 (1994).

26. See Gornick et al., *supra* note 24, at 797 tbl.2.

27. See *id.* (this data covers all angioplasty and bypass surgery in the studied population, not just procedures done in response to an acute myocardial infarction).

28. See, e.g., A. Marshall McBean et al., *Continuing Differences in the Rates of Percutaneous Transluminal Coronary Angioplasty and Coronary Artery Bypass Graft Surgery Between Elderly Black and White Medicare Beneficiaries*, 127 AM. HEART J. 287, 289 (1994) (finding that, in the studied population of Medicare beneficiaries, the rate of percutaneous transluminal coronary angioplasty (PTCA) was higher in white than in African-American patients—2.98 times higher in white men than in African-American men, and 2.05 times higher in white women than in African-American women). But cf. Eric D. Peterson et al., *Racial Variation in the Use of Coronary-Revascularization Procedures: Are the Differences Real? Do They Matter?*, 336 NEW ENG. J. MED. 480, 484 (1997) (concluding that African-American and white patients undergo angioplasty at approximately the same rates, but that African-Americans were significantly less likely than whites to undergo coronary bypass surgery). Not only are African-Americans less likely to undergo coronary surgery, they also are less likely to receive the available drug therapy to improve blood flow to the heart. See Canto et al., *supra* note 3, at 1095–97.

controlled diabetes, at more than three times the rate of equally sick white patients. Likewise, African-American patients with metastatic prostate cancer were more than twice as likely as white patients to undergo bilateral orchiectomy.²⁹ While both diabetes and prostate cancer occur at somewhat higher rates in African-Americans than in whites,³⁰ the differences in populationwide patterns of disease do not fully explain the disparity in the rates of these procedures for similarly situated patients.³¹ The HCFA study data suggest that white Medicare beneficiaries are more likely to receive preventive care and complex therapeutic procedures, while African-American Medicare beneficiaries are more likely to undergo treatments for conditions that could have been prevented or ameliorated through adequate screening and primary care.³² In other words, African-Americans in the study group were "at higher risk for procedures associated with less than optimal management of chronic diseases."³³

Access to renal transplantation provides another complex example of a pattern of underutilization of an optimal treatment for African-Americans. Despite the fact that end-stage renal disease (ESRD) affects African-Americans at a disproportionately high rate,³⁴ these patients are less likely than white patients to be referred as medically appropriate pa-

29. See Gornick et al., *supra* note 24, at 797 tbl.2. In fact, the rates of bilateral orchiectomy actually increase by income for African-Americans and decline by income for white patients. See *id.* at 796 fig.5B. After adjusting for the stage of the disease, when African-Americans and whites receive the same medical treatment for prostate cancer, these groups exhibit similar survival rates. See Scott A. Optenberg et al., *Race, Treatment, and Long-Term Survival from Prostate Cancer in an Equal-Access Medical Care Delivery System*, 274 JAMA 1599, 1604-05 (1995).

30. See, e.g., E. A. Friedman, *Diabetic Neuropathy in Blacks*, 25 TRANSPLANT PROC. 2431, 2431-32 (1993) (noting that African-American men have about twice the incidence of non-insulin dependent diabetes mellitus as white men and that African-American women develop diabetes at four times the rate of white women).

31. See Gornick et al., *supra* note 24, at 798.

32. See DAVID BARTON SMITH, *HEALTH CARE DIVIDED: RACE AND HEALING A NATION* 207-09 (1999).

33. Gornick et al., *supra* note 24, at 798. One important question to consider in evaluating this data is whether alternative, less radical approaches to disease management exist that are medically appropriate for the particular patient. For example, in the case of amputation due to vascular disease associated with diabetes, some patients may qualify for leg-sparing revascularization surgery. It is impossible to determine from the HCFA study data whether African-American patients whose limbs might have been saved by this surgery were denied it. Dr. Satel argues that "thicker arteriosclerosis of the blood vessels in the leg [of African-American patients] makes it harder to perform limb-saving surgery." SATEL, *supra* note 7, at 164. She does not, however, speculate about whether this physiological variation accounts for the entire disparity in the utilization of vascular surgery to avoid amputation. Cf. Edward Guadagnoli et al., *The Influence of Race on the Use of Surgical Procedures for Treatment of Peripheral Vascular Disease of the Lower Extremities*, 130 ARCHIVES SURGERY 381, 384-86 (1995) (finding that variables such as severity of disease, the coexistence of heart disease, geographic location, and type of hospital all impacted the rates of amputation, but did not fully explain the higher rates of amputation in African-Americans).

34. See Robert S. Gaston et al., *Racial Equity in Renal Transplantation: The Disparate Impact of HLA-Based Allocation*, 270 JAMA 1352, 1354 (1993) (noting that although African-Americans constitute twelve percent of the population, they account for thirty-four percent of persons suffering from ESRD in the United States); Carlton J. Young & Robert S. Gaston, *Renal Transplantation in Black Americans*, 343 NEW ENG. J. MED. 1545, 1545 (2000) (noting that by 1997, the rate of ESRD in African-Americans was more than four times that in whites).

tients for renal transplantation.³⁵ Even if referred, African-American patients wait longer to obtain a transplant.³⁶ Recently, researchers have attempted to determine whether the disparities in rates of renal transplantation reflect underuse of the procedure for African-Americans, or overuse of the procedure for white patients.³⁷ Because renal transplantation improves life expectancy and quality of life, and because it costs less than long-term dialysis,³⁸ racial disparities in the use of the procedure based on anything other than purely medical criteria (assuming that investigators control for confounding variables such as insurance coverage) have profoundly troubling implications.

The researchers evaluated a study population consisting of approximately equal numbers of African-American and white patients of similar mean ages. They concluded that referring physicians classified African-American kidney patients as medically appropriate transplant candidates less often than white patients (9.8% versus 21.4%), even after adjusting for income, education, and other variables.³⁹ Even if classified as medically appropriate candidates, African-Americans in the study group received a transplant less frequently than whites. Among medically *inappropriate* patients, physicians still referred white patients for further evaluation and transplant more often than African-Americans, in spite of the presence of medical contraindications.⁴⁰ The investigators concluded that differences in medical appropriateness for transplant that happen to coincide with race explain only a portion of the overall disparity in access to kidney transplantation for African-Americans.⁴¹

35. See Daniel S. Gaylin et al., *The Impact of Comorbid and Sociodemographic Factors on Access to Renal Transplantation*, 269 JAMA 603, 607 (1993) (finding that the health of the potential transplant patient and the presence of other co-morbid factors, along with sociodemographic factors such as female sex, older age, low income, and non-white race, significantly impact the evaluation of whether a particular transplant candidate is "medically qualified").

36. See Ian Ayres et al., *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805, 820 (1993); Raja B. Khauli, *Issues and Controversies Surrounding Organ Donation and Transplantation: The Need for Laws That Ensure Equity and Optimal Utility of a Scarce Resource*, 27 SUFFOLK U. L. REV. 1225, 1231 & n.30 (1993).

37. See Arnold M. Epstein et al., *Racial Disparities in Access to Renal Transplantation: Clinically Appropriate or Due to Underuse or Overuse?*, 343 NEW ENG. J. MED. 1537 (2000).

38. See *id.* at 1537.

39. See *id.* at 1539 (finding that the most common reasons for a determination of clinical inappropriateness were an unacceptably high body mass index (BMI), or the presence of active infection or severe medical conditions apart from the renal disease).

40. See *id.* at 1542. Another study found an even higher disparity in rates of referrals. See Ayanian et al., *supra* note 4, at 1666 tbl.4 (finding that roughly fifty percent of African-American women were referred for evaluation at a transplant center, compared with seventy percent of white women; similarly, about fifty-four percent of African-American men were referred, compared with seventy-six percent of white men).

41. See Ayanian et al., *supra* note 4, at 1667 (concluding that, although patients' preferences about kidney transplantation vary according to race, these differences alone fail to account for the more substantial difference in actual rates of transplantation); Epstein et al., *supra* note 37, at 1542-43 (explaining that "[s]ome might argue that racial disparities mainly reflect underlying clinical differences according to race, and others might counter that racial disparities reflect race-based barriers to the receipt of appropriate care," and concluding that "the situation is more complex than either of these explanations would suggest"). Dr. Satel's discussion of racial inequalities in kidney transplantation examines several variables

Even in conditions for which medical experts agree that a single type of treatment represents the optimal approach, African-American patients receive that optimal care less frequently. For example, African-Americans undergo surgery to treat early-stage lung cancer less often than whites, and, consequently, have a lower overall survival rate for the disease.⁴² A recent study followed nearly 11,000 lung cancer patients over the course of eight years and controlled for variables such as disease stage, insurance coverage, socioeconomic status, access to care, and coexisting illness.⁴³ The investigators found that African-Americans underwent surgical resection of the cancer only 64% of the time, compared with a rate of nearly 77% for white patients in the studied group.⁴⁴ The five-year survival rate for the African-American group was correspondingly lower—approximately 26% versus 34% of white patients—whereas the five-year survival rate among patients who *had* undergone surgery was substantially the same in both racial groups.⁴⁵ Most strikingly, however, surgical resection incontrovertibly represents the optimal treatment for early-stage lung cancer,⁴⁶ leaving little room for the argument that some other, less common, but equally effective, treatment was indicated for any particular patient. Two physicians, commenting on this study, lament that the results

suggest that there is a difference in how physicians manage cancer that is based on a patient's race, regardless of other attributes, and that the consequence of these lapses in care is reduced survival among blacks. Evidence that bias on the part of physicians (either overt prejudice or subconscious perceptions) influences access to optimal cancer care is disheartening⁴⁷

Dr. Satel mentions this study as an example of "the challenges inherent in interpreting health disparities data," noting that, because it consisted of a retrospective evaluation of data, the researchers were unable to determine why the surgery was performed less frequently for African-American pa-

that explain a portion of the disparity in rates of transplantation, but does not acknowledge racial bias as a contributing factor. Instead, she recommends action such as improved communication to increase rates of donation among African-Americans and to promote more living kidney donations from relatives of African-American patients suffering from ESRD. See SATEL, *supra* note 7, at 169–72.

42. See Peter B. Bach et al., *Racial Differences in the Treatment of Early-Stage Lung Cancer*, 341 NEW ENG. J. MED. 1198 (1999); Howard P. Greenwald et al., *Social Factors, Treatment, and Survival in Early-Stage Non-Small Cell Lung Cancer*, 88 AM. J. PUB. HEALTH 1681, 1682–83 (1998) (finding that white patients were twenty percent more likely to undergo surgery than African-American patients, and were thirty-one percent more likely to survive five years, and commenting that "[p]oor general health and adverse health behavior (such as smoking), which often coincide with low income and membership in minority groups, may lead to lower rates of surgery as providers judge disadvantaged patients to be relatively poor surgical risks.").

43. See Bach, *supra* note 42, at 1200–02.

44. *Id.* at 1200.

45. See *id.* The investigators included several caveats to their findings. For example, the study focused on Medicare beneficiaries, and thus did not include patients under the age of sixty-five; the investigators did not assume that patterns of treatment for younger patients would necessarily be consistent with their findings in the studied population. See *id.* at 1203.

46. *Id.* at 1204.

47. Talmadge E. King, Jr. & Paul Brunetta, *Racial Disparity in Rates of Surgery for Lung Cancer*, 341 NEW ENG. J. MED. 1231, 1232 (1999).

tients.⁴⁸ One could make the same point about all health care outcomes research, but the retrospective evaluation of patient data represents an intrinsic limitation rather than a fatal methodological flaw with this type of study.⁴⁹ Moreover, it seems unlikely that patient refusal of a recommended life-saving procedure alone could fully account for the significant disparity in the rates of surgery.

The studies described above demonstrate a pattern of differential utilization of care for minorities that consistently rises above the level of statistical artifact. Of course, not all racial variations in the utilization of a particular health service or procedure provide evidence of racial bias in health care delivery. In some contexts, medical variables provide more neutral explanations for an apparent pattern of disparate care. For example, the HCFA study found that while white women underwent surgical hip-fracture repair 2.4 times as often as African-American women, osteoporosis of the femur (and consequently the likelihood of fracture) is approximately 2.4 times as prevalent in white women as in African-American women.⁵⁰ Similarly, prostate cancer occurs at about the same rate in both populations, but African-American men have 2.2 times the rate of metastatic prostate cancer as white men.⁵¹ Higher rates of bilateral orchiectomy to treat metastatic prostate cancer among African-American men apparently reflect the higher rates of metastasis, which in turn may result from different populationwide trends in the timing of the initial decision to seek medical care for symptomatic prostate disease. Such relatively race neutral explanations, however, account for only a small portion of the demonstrated disparities in the provision of care.

Finally, as Dr. Satel correctly points out, some carefully designed studies of utilization patterns fail to demonstrate significant variation based on patients' race, and studies with equivocal findings lend themselves to misinterpretation.⁵² For the most part, however, variations in the utilization rate

48. See SATEL, *supra* note 7, at 159.

49. See Christopher Anderson, *Measuring What Works in Health Care*, 263 SCIENCE 1080, 1080 (1994); Paul M. Ellwood, *Shattuck Lecture—Outcomes Management: A Technology of Patient Experience*, 318 NEW ENG. J. MED. 1549, 1551 (1988); Arnold M. Epstein, *The Outcomes Movement—Will It Get Us Where We Want to Go?*, 323 NEW ENG. J. MED. 266, 267 (1990); Arnold S. Relman, *Assessment and Accountability: The Third Revolution in Medical Care*, 319 NEW ENG. J. MED. 1220, 1221 (1988).

50. See Gornick, *supra* note 24, at 797–98. Moreover, surgical reduction of hip fracture is a non-elective service; in other words, all hip fractures among Medicare beneficiaries must be treated surgically.

51. See *id.* at 792.

52. See SATEL, *supra* note 7, at 159–63. One study compared mortality rates among hospitalized patients in Veterans' Administration hospitals and concluded that African-American patients had lower mortality rates than white patients: 4.5% in African-American patients versus 5.8% in white patients. See Ashish K. Jha et al., *Racial Differences in Mortality Among Men Hospitalized in the Veterans Affairs Health Care System*, 285 JAMA 297, 300 (2000) (speculating that African-Americans "seek . . . inpatient care at VA medical centers earlier in the course of an illness than do white patients, perhaps because they perceive a diminished barrier to obtaining care at the VA"); see also Kevin A. Schulman et al., *The Effect of Race and Sex on Physicians' Recommendations for Cardiac Catheterization*, 340 NEW ENG. J. MED. 618 (1999). In this unusually designed study, the investigators videotaped white and African-American actors of both sexes who, based on a script, complained of chest pain. *Id.* at 618–25. After viewing a randomly selected video of one actor/patient, the mostly white physicians who participated in the study were asked

of medical procedures represent a complex problem created by the confluence of many factors, including differences in rates of disease, socioeconomic variables, cultural issues, and conscious or unconscious racial bias in health care providers. These studies do not prove a widespread pattern of conscious racism on the part of health care providers, but they do suggest some undercurrent of racial stereotyping and unconscious discrimination.⁵³

B. Racial Profiling of Patients?

The evidence described above suggests that some of the underutilization of optimal medical care for racial and ethnic minorities arises from a subtle form of racial bias. An editorial accompanying the HCFA study reviewed the evidence and speculated about the causes of disparities in the treatment of a large group of Medicare beneficiaries. With some circumspection, the author suggested that racism may play a role in at least a portion of the disparities:

[S]ome other factor is at work. With major confounding variables increasingly controlled and adjusted for, investigators tend to invoke unspecified cultural differences, undocumented patient preferences, or a lack of information about the need for care as reasons for the differences. The alternative explanation is racism—that is, racially discriminatory rationing by physicians and health care institutions. We do not know enough to make that charge definitively. Furthermore, if racism is involved it is unlikely to be overt or even conscious.⁵⁴

The medical and legal community must confront the influence of racial bias in this context, and it is important to do so thoughtfully and precisely.

Although overt racism now receives almost universal public condemnation, racial stereotypes continue to flourish in subtler form. Because times have changed, and racism has changed with the times, it is

whether they would refer the patient for cardiac catheterization. *Id.* The physicians referred the white men, white women, and African-American men at roughly the same rates; only the African-American women actor/patients were referred less frequently. *Id.* at 623. The principle investigator reportedly mis-spoke in a media interview, inadvertently exaggerating the degree of variation in referrals by race, and the media quickly picked up the story, in the process further confounding the study's significance. See SATEL, *supra* note 7, at 160–62. *The New England Journal of Medicine* later published a follow-up article that correctly re-analyzed the data. See Lisa M. Schwartz et al., *Misunderstandings About the Effect of Race and Sex on Physicians' Referrals for Cardiac Catheterization*, 341 NEW ENG. J. MED. 279, 279–80 (1999) (noting that 78.8% of African-American women were referred versus 90.6% of the other groups, but explaining that the investigators “focused their discussion on the results aggregated according to race . . . implying that all blacks (i.e., male and female) were referred less often than all whites”). Dr. Satel speculates that this disparity in referral rate may have resulted from an unpersuasive acting job by one of the female, African-American actors. See SATEL, *supra* note 7, at 258 n.32.

53. Each of the studies described above underwent peer review prior to publication. This gate-keeping process, which attempts to ensure that the science underlying the research and its conclusions are valid, has attracted criticism from commentators who question its effectiveness. See, e.g., Lars Noah, *Sanctifying Scientific Peer Review: Publication as a Proxy for Regulatory Decisionmaking*, 59 U. PITT. L. REV. 677, 693–709 (1998) (describing pitfalls in the editorial peer review process):

54. See Geiger, *supra* note 24, at 816.

useful to differentiate between types of racism when considering the underlying causes of treatment disparities. Scholars describe two fundamental types of racism—the dominative and aversive models.⁵⁵ Dominative racists engage in openly oppressive behavior and explicitly believe in the inferiority of African-Americans and other racial minorities.⁵⁶ In contrast, aversive racists consciously reject dominative racist attitudes, but they have an unconscious tendency to discriminate against racial minorities by using racial and ethnic stereotypes as shortcuts in making judgments and decisions about members of these groups.⁵⁷ Few health care professionals fit the dominative racist model. Most physicians strive for excellent outcomes for all of their patients, but the evidence suggests that unconscious racial bias and stereotyping sometimes interfere with these physicians' ability to deliver the highest quality care to their minority patients.⁵⁸ As one physician writing about bias in the medical profession observed: "[f]ew of us are entirely free from racial prejudice, but we may deny our feelings because they conflict with our self-image as humanitarian and liberal."⁵⁹

Dr. Satel dismisses even subconscious racism as a factor in health disparities, and she believes that biological differences, medically driven treatment decisions, and patient preferences explain most or all of the differential health care utilization patterns.⁶⁰ At the other end of the spectrum, a few commentators have vocally condemned the health care system and its providers as overtly "racist."⁶¹ The reality appears to lie

55. See Edward Patrick Boyle, *It's Not Easy Bein' Green: The Psychology of Racism, Environmental Discrimination, and the Argument for Modernizing Equal Protection Analysis*, 46 VAND. L. REV. 937, 939–40, 944–45 (1993) (reviewing the literature on different classifications of racist behavior and belief).

56. See JOEL KOVEL, *WHITE RACISM: A PSYCHOHISTORY* 54 (1970) (describing dominative racism as openly oppressive of, and hostile towards, African-Americans).

57. See *id.* at 54–55, 60–61; Boyle, *supra* note 55, at 939, 944–45 (noting that aversive racists "take conscious steps to avoid racism within themselves, yet their unconscious prejudgments still influence their decisions," and that they reject their unconscious racist feelings and "reformulate" or "adorn" them with "trappings of logic and reason, in order to survive the scrutiny of the conscious mind"); see also Charles R. Lawrence, III, *The Id, the Ego, and Equal Protection: Reckoning with Unconscious Racism*, 39 STAN. L. REV. 317, 335–36 (1987) (explaining that, "as our culture has rejected racism . . . this hidden prejudice has become the more prevalent form of racism," and that there is now a tendency for individuals to "repress or disguise racist ideas when they seek expression").

58. See David Barton Smith, *Addressing Racial Inequities in Health Care: Civil Rights Monitoring and Report Cards*, 23 J. HEALTH POL. POL'Y & L. 75, 93 (1998) ("At the interpersonal level, this discrimination is shaped by the sense of trust, affinity, and expectations that both providers and patients bring to such encounters. In many cases neither the provider nor the patient leaves such encounters consciously aware of how race mattered.").

59. David R. Levy, *White Doctors and Black Patients: Influence of Race on the Doctor-Patient Relationship*, 75 PEDIATRICS 639, 640 (1985) ("[O]ne effect of racism is to prevent members of different groups from knowing each other as people. This lack of knowledge has negative implications [for quality of care] because an intimate knowledge of the patient by the physician is often essential.").

60. See SATEL, *supra* note 7, at 192 ("The racial disparities in health are real, but data do not point convincingly to systematic racial bias as a determinant.").

61. See Vernellia R. Randall, *Racist Health Care: Reforming an Unjust Health Care System to Meet the Needs of African-Americans*, 3 HEALTH MATRIX 127 (1993); Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy!: An African American Perspective*

somewhere between these extremes. Without presumptively condemning the health care system and its providers as “racist,” many commentators suggest that medical explanations and patient preferences fail to account for most of the disparities in care,⁶² acknowledge the existence of racial stereotyping, and exhort the medical profession to examine its beliefs and practices carefully in light of the evidence demonstrating differential patterns of health care for African-Americans as well as other racial and ethnic minorities.

III. ACHIEVING MEDICAL JUSTICE

The recent mapping of the human genome reveals that individuals of all races share 99.9 percent of their genetic material in common, which means that there is no genetic basis to race.⁶³ This Part explores the impact of racial stereotyping on medical care, and then it considers the concept of cultural competence as a possible antidote. In a previous article, I concluded that available statutory and constitutional remedies provide only a limited and ultimately inadequate mechanism for compensating individual patients who suffer harm as a result of discriminatory medical care.⁶⁴ Because approaches that focus on civil rights litigation appear unavailing in this context, this Part concludes by evaluating the utility of an informed consent tort claim to safeguard the integrity of the doctor-patient relationship for members of a racial or ethnic minority group.

More than a decade ago, civil rights leaders and scholars introduced a series of arguments about the intersection of racial and environmental issues known as the “environmental justice” movement.⁶⁵ In response to

on *Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 231 (1996) (“Eurocentric bioethical principles such as autonomy, beneficence, and informed consent . . . leave considerable room for individual judgment by health care practitioners In a racist society (such as ours), the judgment is often exercised in a racist manner”); Sidney Watson, *Reinvigorating Title VI: Defending Health Care Discrimination—It Shouldn’t Be So Easy*, 58 FORDHAM L. REV. 939 (1990).

62. See, e.g., Council on Ethical & Judicial Affairs, *supra* note 2, at 2345.

63. See Rick Weiss, *Life’s Blueprint in Less Than an Inch; Research: Little of Genome Makes a Human*, WASH. POST, Feb. 11, 2001, at A1. In a fascinating twist along this promising trail of medical discovery, scientists are now debating the ethical problems with mapping racial variations that predispose certain populations to particular diseases such as cancer, diabetes, and schizophrenia. See Nicholas Wade, *For Genome Mappers, The Tricky Terrain of Race Required Some Careful Navigation*, N.Y. TIMES, July 20, 2001, at A17; see also Lila Guterman, *Shades of Doubt and Fears of Bias in the Doctor’s Office*, CHRON. HIGHER ED., May 25, 2001, at A16 (describing the developing controversy among medical researchers over the role of patient race in response to drug therapy and the use of racial categories in medical research in light of improved understanding of the human genome).

64. See Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 156–69 (1998) (reviewing remedies under equal protection doctrine, Title VI of the Civil Rights Act of 1964, and other federal statutes, and concluding that such remedies would be largely ineffective in either compensating patients who received suboptimal health care or deterring biased decision making by physicians).

65. See LUKE W. COLE & SHEILA R. FOSTER, *FROM THE GROUND UP: ENVIRONMENTAL RACISM AND THE RISE OF THE ENVIRONMENTAL JUSTICE MOVEMENT* 19–21 (2001). One of the movement’s important terms, “environmental racism,” reportedly was coined by Benjamin Chavis, the former executive director of the NAACP. See Richard J. Lazarus, *Environmental Racism! That’s What It Is*, 2000 U.

evidence suggesting that racism and economic discrimination inappropriately dictate the siting of environmental hazards, such as toxic waste landfills,⁶⁶ proponents of environmental justice argue for improvements in the decision-making process to avert discriminatory siting decisions.⁶⁷ The EPA now operates under principles of environmental justice that it applies when considering regulatory action. Although there have been no environmental justice amendments to state or federal environmental statutes and no favorable judicial decisions based on claims of environmental racism,⁶⁸ the movement has unmistakably influenced environmental decision making, giving minority and low-income communities a voice in these matters.⁶⁹

As in the environmental context, the problem of disparate health care demands that government, health care institutions, and individual providers recognize the need for justice in the delivery of care. To some extent, the federal government and medical researchers have already taken up the health care justice challenge. The executive branch has acknowledged the magnitude of the problem and undertaken a variety of initiatives focusing on racial disparities in health.⁷⁰ To date, much of the activity involves re-

ILL. L. REV. 255, 257 (describing Dr. Chavis's first use of the term in a speech to the National Press Club in 1987).

66. See, e.g., U.S. GEN. ACCOUNTING OFFICE, SITING OF HAZARDOUS WASTE LANDFILLS AND THEIR CORRELATION WITH THE RACIAL AND SOCIO-ECONOMIC STATUS OF SURROUNDING COMMUNITIES, RCED-83-168 (1983) (noting that, in several communities located near hazardous waste sites, the majority of the population was African-American), available at <http://www.gao.gov/>; Paul Mohai & Bryan Bryant, *Environmental Injustice: Weighing Race and Class as Factors in the Distribution of Environmental Hazards*, 63 U. COLO. L. REV. 921, 926 tbl.1 (1992) (analyzing ten studies comparing the effects of race and income on the location of environmental hazards, and noting that six of the nine studies found race to be a more significant factor in siting decisions); Milo Geyelin, *Pollution Suits Tied to Poor Areas Increasingly Raise Issue of Racism*, WALL ST. J., Oct. 29, 1997, at B3 (explaining that more corporations are defending against challenges to waste dump siting that include a claim of "environmental racism").

67. See Lynn E. Blais, *Environmental Racism Reconsidered*, 75 N.C. L. REV. 75, 77-80 (1996) (providing a brief history of the environmental justice movement); see also Vernice D. Miller, *Equal Protection Under Law: Fact or Fiction?*, 10 FORDHAM ENVTL. L.J. 305, 308-11 (1999) (describing examples of environmental justice litigation, and advocating EPA policies to correct existing instances of disproportionate impact in order to prevent future decision making that would blight the living conditions of minority communities).

68. See Lazarus, *supra* note 65, at 263-64. The Clinton administration did provide some guidance to federal agencies on the principles of environmental justice and required that agencies incorporate these principles into their standard practices. See Exec. Order No. 12,898, 59 Fed. Reg. 7629, 7629-33 (Feb. 16, 1994) (noting that the order does not create any private right of action); see also *Sur Contra La Contaminación v. EPA*, 202 F.3d 443 (1st Cir. 2000) (denying petitioner community organization's challenge to an EPA permit decision on the grounds that the Clinton executive order was intended only to affect internal agency operations and not include a provision for judicial review).

69. See Lazarus, *supra* note 65, at 265-71 (describing categories of change, including enforcement policy, standard setting, public participation, the environmental law profession, and facility siting decisions); see also Noah, *supra* note 64, at 175-77 (proposing an interagency working group to track hospital-wide data and to develop strategies to address identified health disparities).

70. See, e.g., Charles Marwick, *Healthy People 2010 Initiative Launched*, 283 JAMA 989, 989-90 (2000) (announcing the HHS initiative's goals, including the elimination of health disparities). Inadequate access to care represents the most significant underlying cause of health disparities between racial and ethnic minorities and the white population. Problems of access sometimes arise from geographic barriers, and the patient's insurance status or ability to pay also may limit treatment options, but both of

search to understand the causes of varying rates of disease,⁷¹ or proposals to address disparities of access to care and payment issues, rather than focusing on possible discrimination in the delivery of care. The Department of Health and Human Services (HHS) and related governmental agencies should continue to encourage the development of research methodologies that will isolate the effect of race from other variables in the medical decision-making process so that the debate over the significance of these populationwide studies can progress.⁷² Understanding the physiological mechanisms that lead to differential rates of disease in racial and ethnic minorities and improving access to care will not, however, ultimately guarantee health care justice unless minority patients also receive equal treatment from their health care providers.⁷³

A. Individualizing Care

Physicians may be tempted to make a number of generalizations when they first meet and evaluate any patient. Consider, for example, the negative health stereotypes one might attribute to a person who appears to be overweight, who smokes or abuses alcohol, who is very elderly, or who acknowledges having had multiple sexual partners. Physicians may begin their mental assessment of the patient with some medical assumptions about diseases that commonly accompany particular characteristics, but a conscientious diagnostician will not rely on such generalizations as the basis for decisions about appropriate tests or treatments. Instead, medical diagnosis requires that physicians look beyond the patient's visible characteristics or their answers in a medical history questionnaire and evaluate the pa-

these problems are outside the scope of this review. See generally Thomas W. Mayo, *Nonfinancial Barriers to Health Care*, 32 HOUS. L. REV. 1187 (1996).

71. See, e.g., NAT'L INSTS. HEALTH, DRAFT STRATEGIC RESEARCH PLAN TO REDUCE AND ULTIMATELY ELIMINATE HEALTH DISPARITIES, FISCAL YEARS 2002–2006, at 2–3 (Oct. 6, 2000), available at <http://www.nih.gov> (last visited July 1, 2001) (describing coordinated research plans to “strengthen and expand research on the epidemiology and risk factors related to a variety of diseases and conditions that disproportionately affect minority populations,” and noting that “[t]hese disparities are believed to be the result of the complex interaction among biological factors, the environment, and specific health behaviors.”).

72. See Kevin Fiscella et al., *Inequality in Quality: Addressing Socioeconomic, Racial, and Ethnic Disparities in Health Care*, 283 JAMA 2579, 2581 (2000) (describing recent recommendations that the managed care industry collect socioeconomic and racial/ethnic data in its outcomes studies, and noting that HHS now requires sponsored data collection to include racial/ethnic categories); Edward L. Hannan, *The Continuing Quest for Measuring and Improving Access to Necessary Care*, 284 JAMA 2374, 2375 (2000) (“[T]he reasons minorities and the poor have accentuated access problems must be investigated. . . . There is a compelling need to engage in painstaking studies of how treatment decisions are made, including identifying the gatekeepers and determining how patient-clinician interactions influence decisions.”).

73. See John M. Eisenberg & Elaine J. Power, *Transforming Insurance Coverage into Quality Health Care: Voltage Drops from Potential to Delivered Quality*, 284 JAMA 2100, 2101, 2104 (2000). The problems of the medical system described here will likely continue as long as disparities in education and income exist. See Durado D. Brooks et al., *Medical Apartheid: An American Perspective*, 266 JAMA 2746, 2749 (1991) (describing how the apartheid laws in South Africa and the lingering effects of segregation in the United States have negatively impacted medical care for minorities).

tient as an individual, so that they can closely tailor treatment choices to that individual's particular needs.⁷⁴

Even so, the body of research described in Part II suggests that physicians sometimes assess a patient or choose a treatment based on racial stereotypes. Physicians may attribute to African-American patients a variety of stereotypes concerning level of education, dietary practices, or the ability to comply with prescribed care regimens,⁷⁵ and such assumptions may influence how physicians evaluate these patients.⁷⁶ The studies of race-based patterns of health care utilization analyze trends in large populations while controlling for multiple confounding variables, but physicians seldom assess individual patients with reference to populationwide health trends or medical-resource utilization studies. Biases drawn from anecdotal experience may, however, have some impact: to the extent that a physician encounters primarily low-income patients in an inner city medical practice, such a patient population might confirm the physician's intuition that low-income African-Americans suffer from an increased rate of certain health problems. Nevertheless, such generalizations should not serve as the basis for medical decision making.

A careful physician will recognize that most population-specific health patterns arise from problems of inadequate access to health care, particularly primary and preventive care. That same physician will take such patterns into account but will conscientiously evaluate each patient as an individual who may have different health strengths or weaknesses than the "average" patient in the particular population.⁷⁷ In contrast, a racially biased physician may react differently to the pattern of poorer health among African-Americans, concluding that the pattern confirms his or her negative stereotypes about African-Americans. These negative stereotypes may improperly influence such a physician to limit the information or medical

74. Compare, for example, a patient who maintains an ideal weight, and who does not use tobacco or alcohol. A physician would be equally remiss to assume that such a person was healthy based on their appearance, when in fact that person may get no exercise and may consume a diet comprised substantially of high-fat, low-nutrient food.

75. See Steven K. Rothchild, *Cross-Cultural Issues in Primary Care Medicine*, 44 DISEASE-A-MONTH 293, 313-14 (1998) (describing racial stereotypes in medicine).

76. See Jean Lau Chin, *Culturally Competent Health Care*, 115 PUB. HEALTH REP. 25, 28 (2000) (noting that the "prevalence of negative stereotypes about Black and Hispanic groups . . . have resulted in discriminatory practices in health care service delivery"); Levy, *supra* note 59, at 640-41 (describing several "common myth[s] leading to negative stereotyping of blacks").

77. One commentator has noted the importance of distinguishing between cultural generalizations and stereotypes: "While it is useful to know about an individual's culture and the values associated with it, the physician must be careful not to assume that a member of that culture will behave in a certain way based only on that knowledge." Rothchild, *supra* note 75, at 300; see also ERIC J. CASSELL, *THE NATURE OF SUFFERING AND THE GOALS OF MEDICINE* 180 (1991). Cassell notes,

An equivalent danger exists in the characterization of the patient where generalizations, stereotypes, and biases are substituted for a true understanding of the person. . . . General or universal categories, therefore, can either promote or hinder individualization; the choice lies with the person utilizing them. The problem of applying the general to the particular . . . lies in an inadequate knowledge of what makes this individual a particular

This point deserves particular attention when the cultural generalization in question is in fact a negative stereotype.

options that he or she provides to the patient. In other words, while physicians must familiarize themselves with race-based predispositions to particular types of disease, prejudgments or prejudicial assumptions about a patient based on his or her race are not only ethically questionable but also bad medical practice.

When a physician fails to offer a patient the optimal treatment for a particular condition, that physician breaches his ethical duty to the patient. If the cause of the physician's choice of care arises from some racially based stereotype—even an unconsciously held, unacknowledged assumption—rather than a judgment designed to maximize medical efficacy, then the decision amounts to racial discrimination. The documented disparities in care described above suggest that this kind of stereotyping happens with some frequency. Physicians should maintain a vigilant posture against this kind of thinking (or, more accurately, lack of thinking). Simply put, physicians can monitor their level of unconscious racial bias in dealing with an African-American patient by asking themselves a simple question: “If a white patient with the identical condition and medical indications were standing here before me, would I offer him the same treatment options that I am offering this patient?”

B. Cultural Competence

In this increasingly heterogeneous society, physicians will face the challenge of communicating with and treating patients from a tremendous variety of backgrounds. Physicians tend to spend more time with patients like themselves, because communication with such patients feels more comfortable.⁷⁸ When physicians and their patients differ in cultural, socioeconomic, religious, or experiential perspectives, the risk increases that the physician will fail to “hear” the patient's concerns or that the patient will be reluctant to discuss concerns or to ask relevant questions. African-American patients commonly express feelings of dissatisfaction with their physicians and often feel excluded from the process of medical decision making.⁷⁹ The culturally competent physician not only avoids racial stereotyping in evaluating patients but deliberately pursues an ideal of mutual understanding and meaningful communication. A number of commentators have described cultural barriers to physician-patient communication

78. Cf. Barbara M. Korsch et al., *Gaps in Doctor-Patient Communication*, 42 PEDIATRICS 855, 868 (1968) (explaining that physicians spend more time with and give more explanations to patients who seem more intelligent and educated, resulting in a paradox: those patients who need the most information are least likely to receive it).

79. See Lisa Cooper-Patrick et al., *Race, Gender, and Partnership in the Patient-Physician Relationship*, 282 JAMA 583, 586 (1999) (finding that African-American and other minority patients assigned lower participatory decision-making scores to their physicians); King & Brunetta, *supra* note 47, at 1232 (noting that this feeling of exclusion “may be an important factor contributing to miscommunication, increased suspicion of the health care system, and concern about mistreatment”).

and have recommended steps to remove these barriers.⁸⁰ Treating patients with courtesy and respect, taking time to listen to their concerns, and inviting an open discussion of patients' feelings of distrust can help patients express their concerns more effectively.⁸¹

Quality of communication counts, but the length of time devoted to conversation between physician and patient can also significantly impact the success of the interaction. Modern medical practice sometimes resembles a frantic scramble to provide maximum care at minimal cost under an ever-increasing web of managed care guidelines and limitations.⁸² As physicians struggle to adapt to the changing medical marketplace, they rightly mourn the loss of time necessary to develop a thorough knowledge of their patients' needs and preferences through a leisurely conversation.⁸³ The average office visit may not afford the physician sufficient opportunity to give patients detailed instructions about the relative merits of different treat-

80. See, e.g., Leslie J. Blackhall et al., *Ethnicity and Attitudes Toward Patient Autonomy*, 274 JAMA 820, 823-24 (1995) (describing the association between culture/ethnicity and patients' beliefs about disclosure of a diagnosis of terminal illness); Lawrence O. Gostin, *Informed Consent, Cultural Sensitivity, and Respect for Persons*, 274 JAMA 844, 844-45 (1995) (noting that respect for different cultural norms may require physicians to tailor information disclosure to patients of different cultures in ways that clash with formalistic, legal notions of informed consent); Levy, *supra* note 59, at 640 (describing two possible extremes in respectfulness towards patients which physicians would do well to avoid: a negative attitude which, "may manifest itself in many ways, such as keeping the patient waiting, . . . addressing the adult patient by his first name, not introducing oneself to the patient, becoming irritated by the patient's need for explanations and reassurance," and the converse attitude, which may lead the white physician to "overidentify with the black patient, i.e., lean over backwards and become overindulgent, paternalistic, and condescending"); Timothy E. Quill, *Recognizing and Adjusting to Barriers in Doctor-Patient Communication*, 111 ANNALS INTERNAL MED. 51, 52 (1989) (describing signs that may indicate the presence of a barrier to communication); Rothschild, *supra* note 75, at 307-12.

81. See Levy, *supra* note 59, at 642; see also J. Dennis Mull, *Cross-Cultural Communication in the Physician's Office*, 159 W. J. MED. 609, 610-12 (1993) (describing strategies to enhance the quality of communication and decision making).

82. See Edward W. Campion, *Editorial: A Symptom of Discontent*, 344 NEW ENG. J. MED. 223, 224-25 (2001) (noting that "[h]ealth care systems are beginning to hold physicians accountable for everything they do," and that "[t]he demands from third parties for written documentation are another constant distraction, as are their many requirements for prior approval."); Risa Lavisso-Mourey & Elizabeth R. Mackenzie, *Cultural Competence: Essential Measurements of Quality for Managed Care Organizations*, 124 ANNALS INTERNAL MED. 919, 919-20 (1996) (explaining that "the managed care juggernaut" has radically altered health care delivery, and commenting on the clash between managed care imperatives and the values and beliefs of various cultural subgroups).

83. Many physicians and patients believe that managed care has placed pressure on physicians to see more patients and that this pressure has decreased the length of time that physicians spend with patients during office visits. One recent study of office visit times fails to support this perception. See David Mechanic et al., *Are Patients' Office Visits with Physicians Getting Shorter?*, 344 NEW ENG. J. MED. 198, 200 (2001) (concluding that the average length of an office visit has increased by approximately two minutes between 1989 and 1998); see also Randall S. Stafford et al., *Trends in Adult Visits to Primary Care Physicians in the United States*, 8 ARCHIVES FAM. MED. 26, 29 (1999) (noting that the mean duration of primary care physician visits increased from 15.3 minutes in 1978 to 18.1 minutes in 1994). But see Frank Davidoff, *Time*, 127 ANNALS INTERNAL MED. 483, 483 (1997) (citing a study in which forty-one percent of physicians surveyed reported decreasing time spent with patients, and commenting that "[i]t does not take a rocket scientist . . . to understand why both patients and their physicians have become increasingly dissatisfied as visit lengths have grown shorter.").

ment options or about post-visit care or medication use.⁸⁴ Time pressure on physicians also may exacerbate the tendency of some physicians to make assumptions about a patient's treatment preferences or the likely outcome of the chosen treatment based on the patient's race. In the primary care context, however, an extra few minutes spent with patients and the utilization of good communication practices demonstrably increases patient satisfaction.⁸⁵

Finally, a number of commentators have suggested that the paucity of minority health professionals further complicates the relationship between physicians and minority patients.⁸⁶ Ideally, the medical education system will train all physicians to provide high-quality care, with respect and compassion, to all patients, regardless of the race of the physician or patient.⁸⁷ Nevertheless, as part of a commitment to improving the cultural competence of physicians, medical schools should reinvigorate their efforts to recruit an academically qualified and racially diverse student body.

In its famous 1978 decision in *Regents of the University of California v. Bakke*,⁸⁸ which arose in the context of admission to medical school, the Supreme Court agreed that diversity enhances education by introducing students to the novel opinions and experiences of their classmates,⁸⁹ and that

84. See M. Robin DiMatteo, *The Role of the Physician in the Emerging Health Care Environment*, 168 W. J. MED. 328, 329 (1998) (describing research that found that half of the patients surveyed were unable to explain what their physicians had told them or what instructions they had received).

85. It also appears to reduce the likelihood that a patient will file a malpractice claim. See Wendy Levinson et al., *Physician-Patient Communication: The Relationship with Malpractice Claims Among Primary Care Physicians and Surgeons*, 277 JAMA 553, 558 (1997) (finding that primary care physicians who had no malpractice claims filed against them spent an average of about three minutes longer per visit with patients and used more participatory conversation techniques).

86. See Stanley S. Bergen, Jr., *Underrepresented Minorities in Medicine*, 284 JAMA 1138, 1138 (2000) (finding that the number of underrepresented minorities accepted to medical school continued to decline in the 1999–2000 academic year); David M. Carlisle & Jill E. Gardner, *The Entry of African-American Students into U.S. Medical Schools: An Evaluation of Recent Trends*, 90 J. NAT'L MED. ASS'N 466, 467–69 (1998) (noting that the number of African-American medical students peaked in 1994 and has been declining ever since, and that, even at the peak enrollment period, African-American students comprised only 8.1% of the medical student population); Ass'n Am. Med. Colleges, *Questions and Answers on Affirmative Action in Medical Education* (1998), available at <http://www.aamc.org/about/progemph/diverse/qa/pdf> (visited July 1, 2001) (noting that, by 1997, underrepresented minorities—defined as African-Americans, Puerto Ricans, Mexican-Americans, and American Indians—comprised approximately eleven percent of the medical school population, compared with twenty-one percent of the population of the United States).

87. On this point, I agree with Dr. Satel. The amount of time that the physician and patient spend together, not the racial or ethnic “match” between physician and patient, appropriately appears to correlate most closely with patient satisfaction. See SATEL, *supra* note 7, at 175–76 (describing studies suggesting that physician-patient racial match was less important than factors such as reputation, convenient location, and good communication style); *id.* at 182–83 (commenting that “in this era of managed care’s fifteen-minute doctor visit, what much of the research tells us is that most patients attach more value to the amount of time they can spend with their doctor than to the doctor’s race or ethnicity”).

88. 438 U.S. 265 (1978).

89. Justice Powell acknowledged the value of diversity in higher education, but his opinion in *Bakke* considers the constitutionality of affirmative action in higher education as a general matter, attributing the same issues and impacts in all higher education contexts. In discussing the admissions program at Harvard College, he noted that all students benefit from learning in a diverse class setting:

some affirmative action admissions programs can survive constitutional scrutiny.⁹⁰ Yet the *Bakke* opinions fail to differentiate among different educational contexts in considering the arguments for and against affirmative action in university admissions. Because virtually every physician will care for patients of many races and ethnicities during his or her career, no matter what their chosen specialty, the justifications for actively recruiting and admitting minority students seem even more compelling in the context of medical education than in any other higher education setting.⁹¹ In the medical school context, a racially diverse class represents an essential method for exposing white students to the different perspectives and experiences of their minority classmates, so that all of the graduates, not only minority physicians, will be equipped to communicate with and provide optimal care for patients whose race differs from their own.⁹²

Unfortunately, increasing legislative activity and growing public debate concerning the appropriateness of affirmative action have negatively

Contemporary conditions in the United States mean that if Harvard College is to continue to offer a first-rate education to its students, minority representation in the undergraduate body cannot be ignored by the Committee on Admissions. . . .

[T]he race of an applicant may tip the balance in his favor just as geographic origin or a life spent on a farm may tip the balance in other candidates' cases. A farm boy from Idaho can bring something to Harvard College that a Bostonian cannot offer. Similarly, a black student can usually bring something that a white person cannot offer. The quality of the educational experience of all the students . . . depends in part on these differences in the background and outlook that students bring with them.

Id. at 322–23 (appendix to opinion of Powell, J.).

90. Justice Powell (joined by four other Justices) opined that not all affirmative action plans that consider racial diversity are unconstitutional:

In enjoining [the University of California at Davis] from ever considering the race of any applicant, however, the courts below failed to recognize that the State has a substantial interest that legitimately may be served by a properly devised admissions program involving the competitive consideration of race and ethnic origin.

Id. at 320.

91. Compare, for example, the law or business school contexts. Although a diverse class undoubtedly will enhance the learning process for students in such programs, the stakes may be lower. For better or worse, many attorneys or MBAs will enter practices or businesses where they will encounter few if any minority clients.

92. One recent study concluded that African-American and Hispanic physicians were more likely than their white counterparts to practice primary care medicine in medically underserved areas. The study found that minority physicians practice in areas where the percentage of minority residents was nearly five times higher than in areas where white physicians practice. See Joel C. Cantor et al., *Physician Service to the Underserved: Implications for Affirmative Action in Education*, 33 INQUIRY 167, 167 (1996); see also Miriam Komaromy et al., *The Role of Black and Hispanic Physicians in Providing Health Care for Underserved Populations*, 334 NEW ENG. J. MED. 1305, 1307–09 (1996) (noting that the “findings [were] based solely on data from California and may not be generalizable to other states.”); Ernest Moy & Barbara A. Bartman, *Physician Race and Care of Minority and Medically Indigent Patients*, 273 JAMA 1515, 1517 (1995) (finding that minority patients were more than four times as likely to receive regular care from minority physicians). However, other commentators dispute the assumption that minority physicians will practice medicine in geographic areas heavily populated with racial minorities or will otherwise care for disproportionately high numbers of minority patients. See, e.g., CARL COHEN, *NAKED RACIAL PREFERENCE* 51 (1995) (arguing that this assumption fails to justify affirmative action in medical school admissions because, “[i]f the intention to give service to particular segments of the community is to be a consideration in admission to professional school, let that be known, and let all persons, of whatever race, make their case for establishing such intentions, if they claim them”).

impacted the medical school admissions process.⁹³ Dr. Satel condemns affirmative action programs that admit minority candidates whose education has not adequately prepared them for the rigors of medical school,⁹⁴ and she urges continued funding of outreach programs designed to intervene earlier in the educational process in order to increase the pool of qualified minority candidates for medical school.⁹⁵ Programs to improve preparation for medical school undoubtedly will facilitate the academic success of underrepresented minorities and, ultimately, will increase the numbers of minority physicians, but these programs should be used to enhance the impact of affirmative action in medical school admissions rather than to replace affirmative action altogether.

C. *Informed Consent: An Ethical and Legal Mandate*

“Informed consent” refers to both a broad ethical principle that guides the medical profession and a narrower legal doctrine. Physicians have a professional obligation that appears broad enough to require attention to the problems of race and medicine. In fact, medical associations exhort their members to consider issues of race and health care and to respond appropriately. The American Medical Association (AMA), for example, has issued a number of formal statements addressing the problem of racial disparities in health care.⁹⁶ Exhortation alone will not, however, correct widespread disparities in the provision of health services.

93. See Carlisle & Gardner, *supra* note 86, at 470–71 (discussing affirmative action legislation and judicial decisions in California and Texas and concluding that “the spread of anti-affirmative action efforts to other states and continuing litigation in federal courts does not bode well for African-American medical student enrollment”).

94. See SATEL, *supra* note 7, at 185–86 (reviewing evidence suggesting that the admission of underrepresented minority students with substantially weaker academic preparation into medical schools leads to disproportionately higher rates of academic difficulty for these students); see also Stephen N. Keith et al., *Effects of Affirmative Action in Medical Schools: A Study of the Class of 1975*, 313 NEW ENG. J. MED. 1519, 1521–22 (1985) (finding that one-third more minority medical school graduates chose primary-care specialties than their white classmates, and that approximately forty percent fewer minority graduates became board-certified in a specialty); Ethan Bronner, *Study of Doctors Sees Little Effect of Affirmative Action on Careers*, N.Y. TIMES, Oct. 8, 1997, at A1 (finding that students admitted to the U.C. Davis Medical School under special race preferences finished with academic records, and ultimately professional careers, similar to those students admitted on academic merit alone).

95. See SATEL, *supra* note 7, at 189–90.

96. For example, the House of Delegates recently released the following policy statement: The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives . . . [R]acial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue The efforts of specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities.

Am. Med. Ass’n, H-350.974, *Racial and Ethnic Disparities in Health Care* (1998), available at <http://www.ama-assn.org> (last visited July 1, 2001).

The principles underlying the informed consent doctrine in tort law serve important ethical goals. If emphasized as part of medical education and service, these principles will enhance the quality of communication between physicians and their patients and, ultimately, should improve the quality of care. Although current research suggests evidence of differential medical treatment rather than differential consent, the legal framework of informed consent can provide structure and permanence to the ideals of individualized care and cultural competence by encouraging physicians to consider carefully the reasoning underlying their treatment recommendations. This section evaluates the utility of an informed consent claim in tort to address situations in which physicians withhold relevant medical information, and thus medical options, from individual patients based on biases associated with the patients' race or ethnicity. In some cases, a legal claim of negligent failure to obtain informed consent may provide a remedy for patients who have received substandard care, but the threat of such litigation probably will have no lasting impact on the broader problem.⁹⁷ Ultimately, the formal process of informed consent may have more impact on the problem as an ethical guidepost than as a legal sword.

Informed consent rests on several key ethical principles, including patient autonomy (the right of self-determination) and respect for persons,⁹⁸ and thus requires that physicians take into account individual patient preferences and concerns when making treatment recommendations. In situations where the patient's values, preferences, or beliefs differ substantially from the physician's, the "obvious" or "best" option from the physician's perspective may not be consistent with the patient's needs or preferences.⁹⁹ The ideals and values underlying informed consent may be satisfied in dif-

97. Tort litigation may have only a limited impact on the problem in part because African-Americans do not fare well in the tort system. See AUDREY CHIN & MARK A. PETERSON, DEEP POCKETS, EMPTY POCKETS: WHO WINS IN COOK COUNTY JURY TRIALS 26, 37, 58 (1985) (concluding that, in the group of jury trials studied, African-American plaintiffs were less likely to win at trial and more likely to receive smaller awards for a win, and African-American defendants were more likely to lose at trial and more likely to pay smaller awards; therefore jurors apparently discriminate unfairly between African-American and white litigants); Frank M. McClellan, *The Dark Side of Tort Reform: Searching for Racial Justice*, 48 RUTGERS L. REV. 761, 772-74 (1996) (advocating additional empirical research on the effect of race in litigation, and concluding that existing evidence demonstrates that race negatively impacts every aspect of a tort claim); see also Helen Burstin et al., *Do the Poor Sue More? A Case Control Study of Malpractice Claims and Socioeconomic Status*, 270 JAMA 1697 (1993); Molly McNulty, *Are Poor Patients Likely to Sue for Malpractice?*, 262 JAMA 1391 (1989); *Medical Care for All: Questions and Answers*, 260 JAMA 3106 (1988).

98. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 69-70 (3d ed. 1989) (describing the elements of autonomous decisions, including the requirement that such decisions be made with an understanding of the relevant facts); NAT'L COMM'N FOR THE PROT. OF HUMAN SUBJECTS OF BIOMEDICAL & BEHAVIORAL RESEARCH, THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH (1979).

99. See Barbara J. McNeil et al., *Fallacy of the Five-Year Survival in Lung Cancer*, 299 NEW ENG. J. MED. 1397, 1401 (1978) (finding that some patients prefer radiation therapy over surgery because of greater concerns about short-term survival); Barbara J. McNeil et al., *Speech and Survival: Tradeoffs Between Quality and Quantity of Life in Laryngeal Cancer*, 305 NEW ENG. J. MED. 982, 987 (1981) (reporting similar findings); Donald A. Redelmeier et al., *Understanding Patients' Decisions: Cognitive and Emotional Perspectives*, 270 JAMA 72 (1993).

ferent ways according to the desires and needs of the individual patient, but physicians must guard against a tendency to shape the scope of disclosure based on assumptions about the particular patient's willingness or ability to participate fully in making treatment decisions.¹⁰⁰

Informed consent means different things to physicians and lawyers. One commentator, discussing the divergent concepts of informed consent embraced by the legal and medical professions, has captured the essence of the professional clash of cultures.¹⁰¹ Physicians' well-intentioned "excuses" for withholding relevant information from patients arise from deeply entrenched beliefs and habits. In examining physicians' views about the nature of medical care and attitudes towards patients, Jay Katz has observed:

[R]ecognition of the impact of professional irrationalities on physician-patient relations would expose doctors' vulnerabilities to irrational and unconscious thinking in the decision-making process, in what they disclose and do not disclose to patients. Physicians dread recognizing these irrationalities; since they are unaccustomed to and uncomfortable with probing their conduct, they prefer to attribute irrational conduct primarily to patients.¹⁰²

Because of the complex nature of health care decision making, physicians can often point to a medical justification or a perceived patient preference to explain their decision to withhold information about an appropriate medical option and to utilize a suboptimal treatment in its place, even if the decision in fact arose from a conscious or unconscious reaction to the patient's race. When such "irrationalities" intrude on the process of conveying relevant information to the patient, the informed consent doctrine may serve a useful function.

Physicians may omit information or treatment options in conversations with patients for a variety of reasons. A well-intentioned but paternalistic physician may conclude that an apparently anxious patient would prefer drug therapy to a surgical intervention and so may mention but downplay the surgical option in order to influence the patient's

100. The amount of information that a physician discloses to a patient appears to vary according to the patient's socioeconomic status. See 1 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS: A REPORT ON THE ETHICAL AND LEGAL IMPLICATIONS OF INFORMED CONSENT IN THE PATIENT-PRACTITIONER RELATIONSHIP 70-102 (1982).

101. See Michael A. Jones, *Informed Consent and Other Fairy Stories*, 7 MED. L. REV. 103, 103 (1999) ("The failure to tell the truth in the context of the doctor-patient relationship, on the other hand, is often presented as an essential part of therapy. Patients will . . . not understand the information in any event, because it is too complex and technical; patients would become confused by too much information and make the wrong treatment decisions (i.e. not the decision that the doctor would make); doctors do not have time to give full information to patients . . . "); Alan Meisel & Loren H. Roth, *Toward an Informed Discussion of Informed Consent: A Review and Critique of the Empirical Studies*, 25 ARIZ. L. REV. 265, 268 (1983) (commenting that "the imposition of legal requirements that are inefficacious and wasteful of scarce resources may foster contempt for law in general").

102. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* 151 (1984).

decision-making process.¹⁰³ Physicians also may withhold information about alternative treatments so that the patient consents to and receives the therapy that the physician thinks is “best for the patient.”¹⁰⁴ Finally, physicians may assume that their minority patients are less able to comprehend complex medical concepts and thus cannot participate meaningfully in making decisions about their medical care. Lower levels of “health literacy” may make the informed consent process, as it currently operates, far less beneficial to these patient populations.¹⁰⁵ Ironically, patients with lower general literacy levels tend to have higher levels of chronic disease, so that those patients who tend to utilize the health care system most are least likely to comprehend health-related information.¹⁰⁶

Physicians and patients nearly always have unequal levels of medical knowledge. Patients rely on their physicians’ medical expertise in making treatment decisions, but, by definition, decisions are only meaningful if the decision maker has reasonably complete information. The informed consent process is designed to reduce this disparity of medical knowledge by mandating the provision of sufficient information to the patient to allow

103. Meisel & Roth, *supra* note 101, at 334 (explaining that “[i]nformation is given to acquiescent patients to obtain their compliance with treatment, and to resistant patients to overcome their opposition”); see also Jay Katz, *Informed Consent—A Fairy Tale? Law’s Vision*, 39 U. PITT. L. REV. 137, 148 (1977) (opining that doctors often “believe that patients are neither emotionally nor intellectually equipped to play a significant role in decisions affecting their medical fate”).

104. See Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379, 407–09 (1990) (describing the culture of paternalistic medicine); see also Jeffrey N. Katz, *Patient Preferences and Health Disparities*, 286 JAMA 1506, 1508 (2001) (describing a “preference-based paradigm” of medical care, and suggesting that such an approach more effectively involves patients in medical decisions, but observing that this model “may unwittingly reinforce disparities in health resource use.”). Although individual patients differ in their preferences for information, and in their ability to understand complex medical concepts, careful attention to the process of discussing the relative merits of treatment options with patients (rather than simply securing permission to proceed with a particular option) will help to further the ethical goals underlying the informed consent doctrine.

105. See Council on Scientific Affairs, Ad Hoc Comm. on Health Literacy for the Council on Scientific Affairs, AMA, *Health Literacy: Report of the Council on Scientific Affairs*, 281 JAMA 552, 553 (1999) (concluding that a variety of health-related materials, including discharge instructions, contraception instructions, and consent forms, are written at levels well above the average patient’s reading skills); Mark V. Williams et al., *Inadequate Functional Health Literacy Among Patients at Two Public Hospitals*, 274 JAMA 1677, 1679–80 (1995) (finding that approximately thirty percent of English-speaking patients could not understand simple written health instructions and that over sixty percent of the patients in one study location could not read and comprehend a standard informed consent form). These concerns may be exacerbated by a growing racial divide in patient access to Internet-based information, which may further marginalize minority patients. As one commentator put it, “a disclosure-based regime that relies on new information and communications technologies to meet the needs of a broad population . . . may inadvertently widen gaps in quality and access because of socioeconomic differences in availability of, and familiarity with, those technologies.” William M. Sage, *Regulating Through Information: Disclosure Laws and American Health Care*, 99 COLUM. L. REV. 1701, 1822 (1999) (citing Thomas R. Eng et al., *Access to Health Information and Support: A Public Highway or a Private Road?*, 280 JAMA 1371 (1998)). Similarly, in the context of warning labels on consumer products, commentators have suggested that label information provides a far greater benefit to educated consumers. See Lars Noah, *The Imperative to Warn: Disentangling the “Right to Know” from the “Need to Know” About Consumer Product Hazards*, 11 YALE J. ON REG. 293, 372 n.402 (1994).

106. See Council on Scientific Affairs, *supra* note 105, at 553.

participation in making choices about health care.¹⁰⁷ Time pressures or lack of rapport between physician and patient often result in the mechanical operation of the informed consent process. Yet informed consent clearly requires that the physician do more than simply obtain the patient's permission to proceed with a particular treatment option. The doctrine requires that the physician disclose the risks and benefits of the proposed treatment as compared with alternative treatments.¹⁰⁸ The physician who unilaterally decides to pursue a less aggressive or statistically less efficacious course of treatment without regard to patient preference and without fully disclosing the availability of the medically reasonable alternatives fails to conform to the ethical and legal mandate of informed consent.

Two significantly different legal models have evolved in the past quarter century to define the appropriate scope of medical disclosure.¹⁰⁹ The professional standard of informed consent requires disclosure of that information which a reasonable physician would convey under the circumstances.¹¹⁰ The patient-oriented standard asks what a reasonable patient would want to know under the circumstances in order to make an informed decision.¹¹¹ The dichotomy between these two models has important implications for the scope of disclosure in litigation centering around a negligent failure to disclose the *risks* associated with a particular course of treatment,¹¹² but both standards theoretically mandate the disclosure of all relevant treatment alternatives.¹¹³ At this point, however, both versions of the common law informed consent doctrine as well as many statutes bearing on information disclosure focus mainly on risk disclosure.¹¹⁴ Greater use of the

107. See Joan H. Krause, *Reconceptualizing Informed Consent in an Era of Health Care Cost Containment*, 85 IOWA L. REV. 261, 267 (1999).

108. See W. PAGE KEETON ET AL., PROSSER & KEETON ON TORTS § 32, at 190 (5th ed. 1984).

109. States are about evenly divided between the two standards of disclosure. See Anthony Szygiel, *Beyond Informed Consent*, 21 OHIO N.U. L. REV. 171, 207 (1994).

110. See, e.g., *Fain v. Smith*, 479 So. 2d 1150 (Ala. 1985); *Natanson v. Kline*, 350 P.2d 1093 (Kan. 1960).

111. See, e.g., *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972) (concluding that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests seem to lie").

112. The reasonable patient standard appears to encourage a broader level of information disclosure than the professional standard. See Mark A. Hall, *A Theory of Economic Informed Consent*, 31 GA. L. REV. 511, 533-34 (1997); see also Robert Gatter, *Informed Consent Law and the Forgotten Duty of Physician Inquiry*, 31 LOYOLA U. CHI. L.J. 557, 563-67 (2000) (describing how each standard impacts the scope of risk disclosure).

113. See Krause, *supra* note 107, at 322; see also *Bodiford v. Lubitz*, 564 So. 2d 1390, 1391 (Ala. 1990) (reversing summary judgment on claim of negligent failure to inform patient of more conservative alternative treatments); *Smith v. Reisig*, 686 P.2d 285, 285 (Okla. 1984) (inadequate disclosure of hormonal therapy as an alternative to hysterectomy); *Wenger v. Oregon Urology Clinic*, 796 P.2d 376, 377 (Or. Ct. App. 1990) (discussing disclosure of alternative procedures as part of the informed consent process). In some sense, the disclosure required by the professional standard, with its less prominent subjective element, might serve minority patients better, at least in situations where consensus exists about optimal treatment.

114. See FAY A. ROZOVSKY, *CONSENT TO TREATMENT: A PRACTICAL GUIDE* 1:67 (2000); Mary Anne Bobinski, *Autonomy and Privacy: Protecting Patients from Their Physicians*, 55 U. PITT. L. REV. 291, 344-45 (1994); see also Krause, *supra* note 107, at 322, 337-46 (focusing on mandating disclosure of noncovered benefits under insurance plans, suggesting that current developments in informed consent

doctrine to mandate disclosure of treatment alternatives will require a significant shift in emphasis.

Many of the operational criticisms of the informed consent process do not apply to this proposed use of the doctrine. For example, commentators note that the doctrine improperly focuses on the scope of required disclosure from the physician's perspective, rather than on the degree of the patient's understanding.¹¹⁵ Improving patients' understanding of and participation in treatment choices certainly represents an important goal, but the use of informed consent law to mandate the disclosure of treatment alternatives usefully reminds physicians to reconsider their initial judgments about appropriate treatment and can operate independent of the patient's comprehension level. This refocusing of the doctrine on disclosure of treatment alternatives parallels other developments mandating disclosure of information that run against physician self-interest, such as financial conflicts of interest,¹¹⁶ or information about the physician's particular skill and experience in performing a medical procedure.¹¹⁷ Patients certainly may choose to act on the additional information they receive, but, even if they decide to abide by the physician's initial recommendation for treatment, this disclosure process can serve as a reminder to physicians to offer their minority patients all medically appropriate care.

Another common criticism of informed consent law concerns the incongruous requirement that the patient must suffer physical harm in order to receive compensation for a negligent failure to provide informed consent. Because the legal action derives from principles of autonomy and self-determination, the requirement of a physical harm creates an unsettling feeling of inconsistency.¹¹⁸ The law compensates other types of intangible harms, such as emotional distress and breach of privacy, and some commentators have suggested that nondisclosure of risks or treatment alternatives represents a similar type of dignitary harm that deserves compensation, even in the absence of a negative health outcome.¹¹⁹ In most cases, an

law may encourage disclosure of alternative treatments in the future, and proposing mechanisms to encourage such disclosure); *id.* at 312–13 (describing and commenting on the doctrine of “informed refusal,” which suggests that patients have a right to know of the existence of alternative diagnostic procedures so that they can evaluate the risks of foregoing a particular procedure). At least one state statute mandates disclosure of alternate treatments. See WIS. STAT. ANN. § 448.30 (West 1998) (requiring physicians to disclose “alternate, viable medical modes of treatment”); cf. FLA. STAT. ANN. § 766.103(3) (2001) (immunizing physician from liability for negligent failure to obtain informed consent if physician discloses to patient, among other information, the “medically acceptable alternative treatments”).

115. See KATZ, *supra* note 102, at 146–47; Sheldon F. Kurtz, *The Law of Informed Consent: From “Doctor Is Right” to “Patient Has Rights”*, 50 SYRACUSE L. REV. 1243, 1252–53 (2000) (describing factors that interfere with patient understanding and explaining that “the emphasis on disclosure rather than understanding detracts from the underlying rationale for the doctrine”).

116. See, e.g., *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990); see also Krause, *supra* note 107, at 339–40 (noting that the approach in *Moore* could also provide a cause of action for negligent failure to disclose a treatment alternative that is not covered by the patient's insurance plan).

117. See, e.g., *Johnson v. Kokemoor*, 545 N.W.2d 495 (Wis. 1996).

118. See Roger B. Dworkin, *Medical Law and Ethics in the Post-Autonomy Age*, 68 IND. L.J. 727, 729 (1993).

119. See Krause, *supra* note 107, at 365–66.

African-American patient who pursues a cause of action against his or her physician for negligent failure to disclose a viable treatment alternative will do so as a result of having suffered physical harm through suboptimal care, but the argument for conceiving informed consent as a dignitary tort nonetheless seems powerful in this context. If expanded as suggested here, informed consent may provide a tort mechanism to pursue a new kind of civil rights claim in the medical context.

The quality of medical care depends significantly on the effectiveness of the interaction between each physician and patient. The volumes of data demonstrating racial disparities in the utilization of medical care suggest that at least some of the observed differences in the provision of medical care arise from unconscious bias on the part of caregivers. Where there is evidence of racial bias in the choices offered a particular patient, the informed consent doctrine can provide a vehicle for redress for minority patients who have received discriminatory care. The success of a few informed consent actions alleging negligent failure to disclose an important treatment option may deter such activity in the future by encouraging physicians to examine the motivations and assumptions that underlie the choices they offer their minority patients. Perhaps more importantly, informed consent can serve a useful reminder function by encouraging physicians to examine carefully their initial intuitions about treatment recommendations for their patients.

IV. CONCLUSION

Although many of the recommendations suggested above focus on the ethical duty of the physician to inform each patient fully of the available medical options and to assist that patient in pursuing an optimal course of care, it would be reckless to suggest that a simple appeal to the medical community will remedy the problem of racial disparities in the provision of care. A problem of this magnitude warrants systemwide supervision. The environmental justice movement has revealed and begun to discourage discriminatory policies that have a direct, negative impact on minority communities. The federal government has only recently begun to confront the problem of racial disparities in the provision of medical care and it now has a similar opportunity to examine systematically all of its policies in order to expose and correct those that tolerate a disproportionate pattern of medical care for minority patients.

Physicians have the opportunity to improve patient health, or to offer palliative care when disease prevails, and a relationship based on respect, communication, and trust improves the odds for success in both of these undertakings. Although the influence of managed care on medicine may make this ideal difficult to attain at times, surely all patients, whatever their race or background, deserve the physician's best efforts on their behalf. This best effort demands that physicians carefully examine their beliefs and practices and take affirmative steps to communicate effectively with their

patients. Paternalistic or stereotypical assumptions about patients based on race or ethnicity have no place in modern medical care. Instead, all patients deserve the opportunity to participate in medical decision making with information about the full range of treatment options.

Dr. Satel's dismissive reaction to the evidence of racial bias in health care delivery suffers from some of the same flaws as the "indoctrinologist" arguments that she condemns. Her own analysis lacks balance. By highlighting almost exclusively the evidence that supports her position, she is as guilty of politicizing the problem of racial disparities in health as those who reflexively label the health care system and its providers "racist." A careful examination of the evidence of disparate utilization patterns for myriad medical procedures suggests that neither extreme view is correct. Such politicized pronouncements certainly garner public attention for the problem of race-based health disparities (and for the proponents of the extreme views), but less flamboyant, real solutions to the problem will require open-minded cooperation from those with radically different perspectives on the debate.